Department of Labor and Industries

This form must be completed by a vocational Rehabilitation counselor who has received a referral from the state fund.

2nd 52 WEEK PERIOD

RETURN TO WORK PLAN TIME ENCUMBRANCE

☐ Original ☐ Modification

****** Counselor is responsible for sending a copy of this form to each vendor ******

RESET

		Date of this request	Claim number
Assigned Vocational Counselor	VRC provider ID #		
Vocational counseling firm's name	VRC Phone number	Injured worker's name	Date of injury
Address	Firm Provider # & branch	Home address	Phone number
City/State	ZIP+4	City/State	ZIP

Type of Modification:

- ☐ Change in time frames
- ☐ Change in goal
- ☐ Change in training site
- ☐ Change in costs
- ☐ Other (specify) _____

Plan Dates Requested

- ☐ Effective start date
- ☐ Change start date to
- ☐ Interrupt plan on
- ☐ Restart plan on
- ☐ Continue time loss to
- ☐ LEP to start on
- ☐ LEP to end on
- ☐ End date, 2nd 52 weeks
- ☐ Early plan termination

Goal		DOT	
Method	Training site	Contact person	Phone
Date signed	Signature, Assigned Vocational Counselor X		

L&I USE ONLY

Company	Phone No.	FAX No.
Assigned Vocational Counselor:	Date	Signature

For Dept Use Only

Vocational Services Consultant ☐ Recommended ☐ Not Recommended	Date	Phone No.	Signature
Supervisor of Industrial Insurance ☐ Approved ☐ Not Approved	Date	Phone No.	Signature